TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
NW SURGERY CENTER RED OAK

Respondent Name
TRAVELERS INDEMNITY CO

MFDR Tracking Number
M4-16-0039-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
SEPTEMBER 4, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am requesting reconsideration for the above referenced patient and the amount paid. Medicare's fee schedule for CPT 26356 ASC is $1,194.93 X 235% is $2,808.09. Coventry's reprising would make it $2,751.93 which means the claim underpaid this code by $601.08…Both CPT codes 64702 and 26455 are column 2 codes requiring a modifier. 64702 has modifier LT and the estimated due is $861.69. CPT 26455 has an F4 and an estimated due with that code is $764.73. Both modifiers are allowed to differentiate between the services according to the NCCI guidelines."

Amount in Dispute: $1,659.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier contends the services in dispute have been properly reimbursed in accordance with the certified healthcare network's outpatient fee schedule, as they are included in the reimbursement for other services on the same date of service."

Responses Submitted By: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 11, 2015	Ambulatory Surgical Care for CPT Code 64702-LT	$1,659.62	$0.00
	Ambulatory Surgical Care for CPT Code 26455-F4		

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 243-The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
   - 97-Allowance included in another service.
   - 5335-Per the NCCI Outpatient Code Editor, your services have been disallowed.
   - 974-This procedure is included in the basic allowance of another procedure.
   - W3-Additional payment made on appeal/reconsideration.

Issues

Is the requestor entitled to additional reimbursement for services rendered March 11, 2015?

Findings

1. 28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."
2. On the disputed date of service, the requestor billed CPT codes 26356-F4, 64702-LT and 26455-F4.
3. According to the submitted explanation of benefits, the respondent denied reimbursement for codes 64702-LT and 26455-F4 based upon reason codes "243," "97," and "974."
4. Per National Correct Coding Initiative Edits, CPT codes 64702 and 26455 are a component of code 49507; however a modifier is allowed to differentiate the service. A review of the submitted medical billing finds that the requestor appended modifiers "LT" and "F4". The Division finds that all the surgical procedures were performed to left fifth finger; therefore, the modifiers used do not differentiate the disputed services from code 26356-F4. As a result, reimbursement is not recommended.

5. Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		11/5/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.